Benefits Choices 2010

Retirees

OPEN ENROLLMENT

Annual Open Enrollment
October 26 - November 10, 2009

Health
Benefits
Employee Services

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Health Benefits Employee Services
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Your Health. Take Charge.

2010 Benefits Choices
ANNUAL OPEN ENROLLMENT

October 2009

Dear Sandia Retiree,

Sandia National Laboratories is conducting our annual Open Enrollment for Health Plan Choices for 2010. Refer to this booklet and your packet to get important information on the options and changes for the next year.

IMPORTANT:
IF YOU HAVE NO CHANGES, THERE IS NO ACTION NECESSARY.

If you need or want to change your health plan(s) or that of your dependents that are covered by medical or dental, please complete the change form located in this booklet. If you have questions about your benefits, submit your question via email to http://hbe.sandia.gov. If you do not use email, in Albuquerque, call (505) 844-HBES (4237). If you are located outside of Albuquerque, call (800) 417-2634, and then dial 844-4237. Please leave a detailed message. A Benefits representative will call you back as quickly as possible.

2010 Changes - High Level Overview

- Introduction of the Sandia Total Health administered by UnitedHealthcare with a Health Reimbursement Account for Pre-Medicare retirees and dependents
- Introduction of Pre-Medicare/Medicare combination (combo) family coverage for retirees and family members enrolled in Sandia Total Health and Medicare family members enrolled in the New Mexico Presbyterian MediCare Preferred Provider Organization (PPO) Plan.
- Sandia no longer offers a 6 month premium share grace period to surviving spouses for the first six months (see Surviving Spouse Medical Premiums section for premium rates).
- For plan changes refer to each plan description

2011 Changes

- Pre-Medicare – UHC Premier PPO, CIGNA In-Network and Kaiser Permanente Traditional Plan will be eliminated (see note below). Sandia Total Health will be the only Sandia-sponsored Pre-Medicare medical plan.
- Medicare – UHC Senior Premier PPO Plan will be eliminated. Sandia-sponsored group plan(s) offered will be Medicare Advantage plans. In order to enroll in the Sandia-sponsored Medicare Advantage plan, you must have Medicare Part A and B.

Note: Sandia is required to do competitive source selection for medical plan administrative services contractors for both the Sandia Total Health and Sandia-sponsored Medicare Advantage program(s) for 2011 and beyond. Network providers (e.g., physicians and facilities) disruption will be taken into consideration during this process. Sandia's objective is to contract with Kaiser Permanente under an arrangement that allows the Sandia Total Health plan design. The outcome of the source selection process will be announced in time for the 2011 Open Enrollment period.

To ensure you understand the changes, we recommend you carefully review all the information in this booklet and review the Medical Plan Comparison Charts included in this package. You may also visit our web site at **http://hbe.sandia.gov** for more information.

Sandia Benefits Department

Welcome to Open Enrollment Benefits Choices 2010

It is time again to make your benefits decisions for the coming year. This booklet is designed to offer a brief look at each of the plans available during Open Enrollment. There are a number of important changes to the health plans offered in 2010. We recommend you carefully review all the information in this booklet and the Medical Plans Comparison Chart included in this package.

Sandia's Open Enrollment period for Benefits Choices 2010 will run from October 26 to November 10, 2009.

All enrollment changes (including to add/drop a dependent) require completion of the Open Enrollment Change Form included in this booklet. For Medicare Advantage Plan enrollment, you must also complete the Group Medicare Advantage Form included in this booklet. The Open Enrollment Change Form must be postmarked on or before November 10, 2009. All benefit changes take effect January 1, 2010, for the 2010 calendar year.

Summaries in this booklet are condensed information pieces and do not replace or modify the Summary Plan Descriptions for the plans.

IMPORTANT

- **All changes must be mailed and postmarked by November 10, 2009 or they will not be accepted.**
- **If you have NO CHANGES, you do not need to complete the Open Enrollment Form.**

Do you need to complete an Open Enrollment Change Form?

	Take Action	No Action
Medical Coverage	• To enroll if not currently enrolled • To change your current medical plan • To add or disenroll a dependent • To waive coverage	No change in your current medical coverage
Dental Coverage	• To enroll if not currently enrolled • To change your current medical plan • To add or disenroll a dependent • To waive coverage	No change in your current dental coverage

SANDIA TOTAL HEALTH

The Sandia Total Health is administered by UnitedHealthcare (UHC). This Consumer Directed Health Program allows members to see any licensed provider, although benefits are greater when care is received from a UHC network provider. This program includes an employer funded Health Reimbursement Account.

Sandia Total Health Key Points

Eligibility:

This plan is available to Pre-Medicare retirees, and their Pre-Medicare primary Class I and Class II dependents.

- If your eligible dependent is Medicare-primary, and you enroll in this Plan, you must enroll your dependent(s) in the Presbyterian Medicare Preferred Provider Organization (PPO) Plan.

Changes Effective January 1, 2010:

- This is a new medical plan option for 2010.

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO, UHC Senior Premier PPO, CIGNA In-Network and Sandia Total Health.
- Prior notification to UHC is required for certain medical services, procedures, and hospitalizations.
- Members are responsible for the first $300 of covered charges for failure to follow notification and/or precertification procedures.
- Certain in-network preventive care is covered at 100% before the deductible is met. It is solely up to the provider as to whether the service is coded as “preventive or diagnostic”. Neither Sandia nor UHC can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.
- This plan provides in- and out-of-network benefits.
- Coverage is available worldwide for emergency and urgent care.
- Prescription drug copays do not apply to the out-of-pocket maximums. Prescription drugs have an independent individual $1,500 out-of-pocket maximum.
- Prescription drug copays do not apply to the deductibles.
- Behavioral health benefits are provided through the OptumHealth Behavioral Solutions network of providers. Precertification to OptumHealth Behavioral Solutions is required before you receive certain behavioral health services.

Health Reimbursement Account (HRA)

The HRA account is administered by UnitedHealthcare. The HRA gives you direct access to your healthcare dollars and the benefit of reimbursing you for some of your out-of-pocket costs. Pre-Medicare retirees receive the maximum contribution upon completion of a UHC Health Assessment and completion of biometric screening obtained during your annual physical.

Note: The HRA account should not be confused with a Flexible Spending Account. The HRA is not a Flexible Spending Account. Your HRA will be established under the health expense reimbursement component of the Sandia Total Health. This component of the Sandia Total Health allows Sandia to allocate a specified amount of dollars into an HRA on a calendar year basis in your name. The amount of dollars allocated to your HRA is determined by Sandia and depends on the coverage category you choose. Amounts allocated are per coverage category and not per family member.

Pre-Medicare retirees can complete the Health Assessment and biometric screening anytime between January 1, 2009 and December 31, 2009. In order to have your HRA amount available to you on January 1, 2010, you must complete the Health Assessment and biometric screening by December 31, 2009. Pre-Medicare retirees will have a 90-day grace period after the required December 31, 2009 deadline to schedule and see your Primary Care Physcian (PCP) to get the required screening. The HRA account will be available by April 30.

In 2011, the Sandia Total Health with HRA will be the only plan offered to Pre-Medicare retirees. If you remain enrolled in the Sandia Total Health for subsequent years, and have continual coverage with no break, to have your HRA funded by January 1, you will have to complete the Health Assessment and biometric screening at any time during the year, but they must be done prior to December 31 of your enrollment year. For more information on the Health Assessment and biometric screening, see the section entitled "Pre-Medicare Health Assessment and Biometric Screening " included at the back of this booklet.

Coverage Category	Annual Allocation of HRA Dollars if Health Assessment and biometric screening are taken[1]	Annual Allocation of HRA Dollars if Health Assessment and/or biometric screening are NOT taken[1]
Primary Covered Member Only	$250	$0
Primary Covered Member + Spouse or +Child(ren)	$500	$250
Primary Covered Member + Spouse + Child(ren) (also referred to as family)	$750	$500

[1]This is the only amount that will be placed in your HRA during the calendar year and may be used for any combination of Network and non-Network Covered Health Services, including prescription drugs purchased through Catalyst Rx.

Member Resources:

UnitedHealthcare Member Service (877) 835-9855
Access to UHC member services 24 hours a day, seven days a week

OptumHealth Behavioral Solutions (866) 828-6049
Access to OptumHealth Behavioral Solutions member services

Optum NurseLine (800) 563-0416
Provides access to a 24-hour nurse advice line

Care Coordination
Gives you personal support and easy access to information that will help you manage your health or condition, and make smart choices for the future. Contact UHC member services to find out more about this program.

Personal Health Support and Disease Management
Management programs for chronic conditions, complex health care needs and assistance with treatment decisions with comprehensive programs for coronary artery disease, diabetes, heart failure, and asthma. Contact UHC member services to find out more about these programs.

Comprehensive Website www.myuhc.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card, personal health assessments and more.

UnitedHealth Allies (800) 860-8773
Save 10 to 50 percent on many health care products and services not paid for by your plan. Visit www.unitedhealthallies.com to learn more.

Selecting a Network Provider:
For a listing of in-network providers, you can go to the online Provider directory at www.myuhc.com. The username and password is SNL.

Additional Information:
For additional information on this Plan, refer to the Sandia Total Health program document at http://www.sandia.gov/benefits/spd/index.html, and the Retiree Medical Plans Comparison Chart.

UNITEDHEALTHCARE (UHC) PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The UnitedHealthcare (UHC) Premier PPO Plan is administered by UnitedHealthcare. This PPO Plan allows members to see any licensed provider, although benefits are greater when care is received from a UHC network provider.

UnitedHealthcare Premier PPO Plan Key Points

Eligibility:

This plan is available to Pre-Medicare retirees, and their Pre-Medicare Class I and Class II dependents.

Note: If your dependent is Medicare-primary and you enroll in this Plan, you can only enroll your dependent in the UHC Senior Premier PPO Plan. Class II dependents who are Medicare-primary will be enrolled in the UHC Senior Premier PPO Plan.

Changes Effective January 1, 2010:

- Behavioral Health Benefits
  Mental Health and Substance Abuse Inpatient
  - 90 day combined maximum no longer applies for in-network and out-of-network
  - Out-of-network coinsurance applies to out-of-pocket maximum

  Mental Health and Substance Abuse Outpatient
  - In-network - From 15% of negotiated fees to $35 copay per office visit
  - Out-of-network – From 50% of eligible expenses to 30% of eligible expenses per office visit

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO, UHC Senior Premier PPO, CIGNA In-Network and Sandia Total Health.
- Prior notification to UHC is required for certain medical services, procedures, and hospitalizations.
- Members are responsible for the first $300 of covered charges for failure to follow notification and/or precertification procedures.
- Certain in-network preventive care is covered at 100% before the deductible is met. It is solely up to the provider as to whether the service is coded as “preventive or diagnostic”. Neither Sandia nor UHC can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.
- This plan provides in- and out-of-network benefits.
- Coverage is available worldwide for emergency and urgent care.
- Prescription drug copays do not apply to the out-of-pocket maximums.
- Prescription drug copays do not apply to the deductibles.
- Behavioral health benefits are provided through the OptumHealth Behavioral Solutions network of providers. Precertification to

OptumHealth Behavioral Solutions is required before you receive certain behavioral health services.

Member Resources:

UnitedHealthcare Member Service (877) 835-9855
Access to UHC member services 24 hours a day, seven days a week

OptumHealth Behavioral Solutions (866) 828-6049
Access to OptumHealth Behavioral Solutions member services

Optum NurseLine (800) 563-0416
Provides access to a 24-hour nurse advice line

Care Coordination
Gives you personal support and easy access to information that will help you manage your health or condition, and make smart choices for the future. Contact UHC member services to find out more about this program.

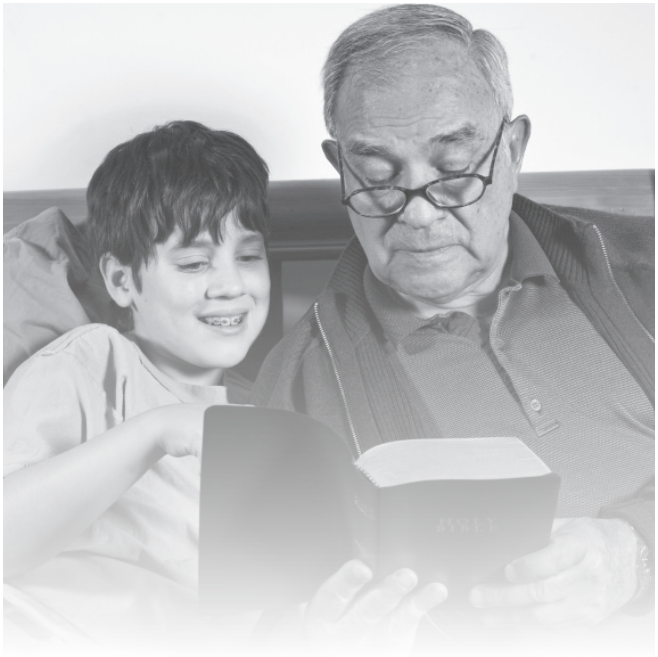
Personal Health Support and Disease Management
Management programs for chronic conditions, complex health care needs and assistance with treatment decisions with comprehensive programs for coronary artery disease, diabetes, heart failure, and asthma. Contact UHC member services to find out more about these programs.

Comprehensive Website www.myuhc.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card, personal health assessments and more.

UnitedHealth Allies (800) 860-8773
Save 10 to 50 percent on many health care products and services not paid for by your plan. Visit www.unitedhealthallies.com to learn more.

Selecting a Network Provider:
For a listing of in-network providers, you can go to the online Provider directory at www.myuhc.com. The username and password is SNL.

Additional Information:
For additional information on this Plan, refer to the UnitedHealthcare Premier PPO program document at http://www.sandia.gov/benefits/spd/index.html, and the Retiree Medical Plans Comparison Chart.



UNITEDHEALTHCARE (UHC) SENIOR PREMIER PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The UnitedHealthcare (UHC) Senior Premier PPO Plan is administered by UnitedHealthCare. This PPO allows members to see any licensed provider in- or out-of-network.

UnitedHealthcare Senior Premier PPO Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, and their Medicare-primary Class I and Class II dependents.

Note: If your Class I or II dependent is pre-Medicare and you enroll in this Plan, you can enroll your dependent in the UHC Premier PPO Plan.

Changes Effective January 1, 2010:

- Behavioral Health Benefits
  Mental Health and Substance Abuse Inpatient
  - 90 day combined maximum no longer applies for in-network and out-of-network
  - Out-of-network coinsurance applies to out-of-pocket maximum

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier PPO Plan, CIGNA In-Network Plan and Sandia Total Health.

- Members in the UHC Senior PPO Plan will be considered as having both Medicare Part A and Part B coverage for purposes of coordinating with Medicare and processing claims.

- Certain in-network preventive care is covered at 100%. It is solely up to the provider as to whether the service is coded as "preventive or diagnostic". Neither Sandia nor UHC can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

- After the covered member has reached the $1,000 out-of-pocket maximum (not applicable to outpatient prescription drugs or out-of-network behavioral health benefits), benefits will be coordinated with Medicare.

- Provides in- and out-of-network benefits

- Coverage is available worldwide for emergency and urgent care.

- Prescription drug copays do not apply to the out-of-pocket maximum.

- Behavioral health benefits are provided through the OptumHealth Behavioral Solutions network of providers.

- Participants have a lifetime maximum (with the exception of outpatient prescription drugs) of $150,000. The first $3,500 paid out annually does not apply to the lifetime maximum. If you reach the $150,000, the Plan will only pay $3,500 per year in benefits.

Member Resources:

UnitedHealthcare Member Service
(877) 835-9855
Access to UHC member services 24 hours a day, seven days a week

OptumHealth Behavioral Solutions (866) 828-6049
Access to OptumHealth Behavioral Solutions member services

Optum NurseLine (800) 563-0416
Provides access to a 24-hour nurse advice line

Care Coordination
Gives you personal support and easy access to information that will help you manage your health or condition, and make smart choices for the future. Contact UHC member services to find out more about this program.

Personal Health Support and Disease Management
Management programs for chronic conditions, complex health care needs and assistance with treatment decisions with comprehensive programs for coronary artery disease, diabetes, heart failure, and asthma. Contact UHC member services to find out more about these programs.

Comprehensive Website www.myuhc.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card, personal health assessments and more.

UnitedHealth Allies (800) 860-8773
Save 10 to 50 percent on many health care products and services not paid for by your plan. Visit www.unitedhealthallies.com to learn more.

Selecting a Network Provider:
For a listing of in-network providers, you can go to the online Provider directory at www.myuhc.com. The username and password is SNL.

Additional Information:
For additional information on this Plan, refer to the UnitedHealthcare Senior Premier PPO program summary at http://www.sandia.gov/benefits/spd/index.html, and the Retiree Medical Plans Comparison Chart.

CIGNA IN-NETWORK PLAN

This medical plan is administered by CIGNA HealthCare. This Plan is an HMO look-alike plan. This Plan provides an open access network, which means that members can see any in-network specialist without a referral. Benefits are available only from in-network (CIGNA-contracted) providers. There is no out-of-network coverage under this Plan.

CIGNA In-Network Plan Key Points

Eligibility:

This Plan is available to Pre-Medicare retirees, and their eligible Pre-Medicare Class I dependents.

Notes:

- Class II dependents are not eligible.
- Medicare-primary individuals are not covered under this Plan (including those with end-stage renal disease who become Medicare-primary)
- If your eligible dependent is Medicare-primary, and you enroll in this Plan, you must enroll your dependent(s) in the Lovelace Senior Plan.

Changes Effective January 1, 2010

- Behavioral Health Benefits

  Mental Health Inpatient
  - Maximum of 45 days per calendar year no longer applies

  Substance Abuse Inpatient
  - Maximum of 15 days per calendar year no longer applies

  Mental Health and Substance Abuse Outpatient
  - Maximum of 30 visits per calendar year no longer applies

Guidelines:

- The prescription drug program is administered through Catalyst Rx. See Prescription Drug Coverage for UHC Premier PPO Plan, UHC Senior Premier PPO Plan, CIGNA In-Network Plan and Sandia Total Health.
- Prescription drug copays do not apply to the out-of-pocket maximums.
- Coverage is provided for services from in-network providers only.
- Emergency and urgent care needs are covered at the in-network benefit level. Any follow-up care must be received from an in-network provider.
- Copays apply to your annual out-of-pocket maximum, except for prescription drugs. The out-of-pocket maximum is your total financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of the calendar year.
- You or a family member must call CIGNA within 48 hours (or as soon as reasonably possible) whenever hospitalized for any out-of-network emergency care. Call CIGNA Member Services at (800) CIGNA24 (244-6224) for details.

Member Resources:

CIGNA Member Services (800) CIGNA24 or (800) 244-6224

Access to member services 24 hours a day, seven days a week

Nurse Advice Line (800) 244-6224
Access to a 24-hour nurse advice line available 24 hours a day, seven days a week

"Well Aware for Better Health"
This is a voluntary program to help members manage chronic conditions for asthma, diabetes, heart disease, low back pain, and chronic obstructive pulmonary disease. Members receive personalized guidance and support from an experienced registered nurse, as well as receive reminders about important screenings and exams.

Comprehensive Website for members at www.mycigna.com
Provides access to health information, to print Explanation of Benefits (EOB) online, order a new or replacement ID card or print a temporary ID card and more.

CIGNA Healthy Rewards (800) 870-3470
Offers discounts to CIGNA members for non-traditional health and wellness programs. Aim for a better and more healthful lifestyle by taking advantage of the discounts. To learn more about the Healthy Rewards providers, call (800) 870-3470 or visit www.cigna.com/healthyrewards.

Selecting a Network Provider:
For a listing of network providers, non-members can access the listing online at www.cigna.com. Select the CIGNA Open Access Only option.

Additional Information:
For additional information on this Plan, refer to the CIGNA In-Network program document at http://www.sandia.gov/benefits/spd/pdfs/, and the Retiree Medical Plans Comparison Chart.

PRESCRIPTION DRUG COVERAGE FOR UHC PREMIER PPO, UHC SENIOR PREMIER PPO, CIGNA IN-NETWORK AND SANDIA TOTAL HEALTH

Prescription Drug Program Key Points

Eligibility:

Members eligible for coverage under the UnitedHealthcare (UHC) Premier PPO, UnitedHealthcare (UHC) Senior Premier PPO, CIGNA In-Network and Sandia Total Health are eligible for the Prescription Drug Program. The Prescription Drug Program is administered by Catalyst Rx. Plan members who have primary prescription drug coverage under another group health care plan are not eligible to use the Mail-Order Program or to purchase drugs from retail network pharmacies at the copayment level.

Important: If you are Medicare eligible, you are not required to enroll in a Medicare drug plan. If you and/or your covered dependents enroll in a Medicare Part D prescription drug plan for 2010, refer to the Creditable Coverage Disclosure Notice for 2010 for information on how this may impact your prescription drug coverage through Sandia.

UHC Premier, Senior Premier Plan and CIGNA In-Network Changes Effective January 1, 2010

Prescription Drug – Retail (maximum 30-day supply and Mail Order (maximum 90-day supply)

- None

Sandia Total Health Prescription Plan Effective January 1, 2010

Prescription Drug Vendor: Catalyst Rx

Retail (maximum 30-day supply)

- Generic – 20% of retail network price
- Preferred Brand – 30% of retail network price
- Non Preferred Brand – 40% of retail network price

Mail Order (maximum 90-day supply)

- Generic – 20% of mail order price
- Preferred Brand – 30% of mail order price
- Non Preferred Brand – 40% of mail order price

Sandia Total Health includes a $1,500 prescription drug individual in-network annual out-of-pocket maximum. This means that once you reach the out-of-pocket maximum any eligible drugs will be covered at 100% in-network for the remainder of the calendar year.

Guidelines:

- **Mandatory Specialty Drug Program Overview** In order to receive coverage for specialty medications, these drugs must be purchased through the Catalyst Rx Specialty Drug Management Program. These drugs are delivered via mail order through the Specialty Pharmacy (Walgreens). All specialty prescriptions will be limited to a 30 day supply and will be subject to the retail coinsurance/ copay structure (e.g., 30% coinsurance with a $25 minimum copay and $40 maximum copay for a preferred brand drug). Note: The copay structure does not apply to retirees/spouses covered under the Sandia Total Health.

- You must show your Catalyst Rx identification card to obtain the applicable copayment

at a retail network pharmacy. If you do not show your Catalyst Rx identification card upon purchase to identify you as a Sandia participant, you will not be eligible for any reimbursement.

- Maximum of 30-day supply at retail network and out-of-network retail pharmacies.
- Reimbursement for a paper claim submitted for purchases at in-network pharmacies will not be allowed (except for coordination of benefits).
- Prescriptions drug copayments and/or coinsurance do not apply to the UHC Premier PPO Plan and Sandia Total Health deductibles or out-of-pocket maximum.
- Prescription drug copayments and/or coinsurance do not apply to the UHC Senior Premier PPO Plan or CIGNA In-Network Plan out-of-pocket maximum.
- If the actual cost of the prescription through the mail or at a retail network pharmacy is less than the copayment, you will only pay the actual cost.
- Under the mail-order program, unless your physician specifies that the prescription be dispensed as written, prescriptions will be filled with the least expensive acceptable generic equivalent when available and permissible by law.
- Under the mail-order program, you must ask for a 90-day prescription with refills in 90-day increments.
- Certain prescriptions will only be dispensed with an appropriate medical diagnosis through the prior authorization process. In addition, some drugs may be subject to step therapy protocol. For more information, call Catalyst Rx at (866) 854-8851.

Important for New Enrollees in the Catalyst Rx prescription drug program

Catalyst Rx "welcome kits" containing your new identification cards, mail order forms and envelope with mail order transition information, an abbreviated preferred brand-name drug list, as well as other important information will be mailed to home addresses in late December.

Member Resources:

Catalyst Rx Customer Service
(866) 854-8851
Catalyst Rx Customer Service Representatives will be available 24 hours a day, seven days a week.

Walgreens Specialty Pharmacy
(866) 823-2712
Walgreens Specialty Pharmacy customer service offers support, counseling and assistance with medication management Monday through Friday, 6:00 a.m. to 5:00 p.m. (MST).

Interactive Website at www.catalystrx.com (user id and password: SNL)
You can view the details of your benefit program, locate a participating pharmacy, or locate the plan formulary.

For additional information on this Program, refer to the individual medical program document at http://www.sandia.gov/resources/emp-ret/spd/index.html, and the Retiree Medical Plans Comparison Charts.

LOVELACE SENIOR PLAN (LSP)

The Lovelace Senior Plan (LSP) is a Medicare Advantage Plan with prescription drug benefits. This Plan is fully-insured through the Lovelace Health Plan for eligible Medicare-primary participants who live in New Mexico. Benefits are available only from providers who are in the Lovelace Health System network.

Lovelace Senior Plan Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, and their eligible Medicare-primary Class I dependents. Additionally, you are eligible for membership if you are:

- Entitled to Medicare Part A and are enrolled in Medicare Part B,
- Not receiving benefits due to end-stage renal disease (with a few exceptions), and
- Continue to pay your Medicare Part B premiums after joining the Lovelace Senior Plan.

Notes:

- In order to enroll in this plan, you or your dependents must be Medicare-primary on January 1, 2010. If your eligible dependent is pre-Medicare, and you enroll in this Plan, you can enroll your dependent(s) in the CIGNA In-Network Plan.

- Class II dependents are not eligible.

IMPORTANT: You must complete the Group Medicare Advantage Plan application form and return it with your Sandia Open Enrollment Change Form. A copy of the form is included in this booklet.

Changes Effective January 1, 2010*:

Behavioral Health
Group Therapy Visits from $15 copay to $20 copay

Part D Prescription Catastrophic Level In-Network and Out-of-Network
From: After the member's yearly out-of-pocket drug costs reach $4,350, they pay:
- $2.25 for Generic
- the greater of $5.60 or 5% coinsurance for all others

To: After the member's yearly out-of-pocket drug costs reach $4,550, they pay:
- $2.50 for Generic
- the greater of $6.30 or 5% coinsurance for all others

Vision Services from Administered by Lovelace Senior Plan to Administered by VSP

New Benefit - Assist America
Assist America is a provider of global emergency services. The Assist America shield is activated whenever a member travels more than 100 miles from home or to another country. Services, which are fully paid by Assist America, include:

- Medical consultation and referrals
- Medical evacuations
- Medical repatriations
- Prescription assistance
- Foreign hospital admission guarantee
- Critical care monitoring
- Emergency message service
- Return of mortal remains
- Care of minor children left unattended
- Legal, interpreter, counseling referrals due to a medical incident

Guidelines:

- Primary Care Physician (PCP) is required. You must select a PCP or one will be assigned to you. Obtain a directory by contacting Lovelace Customer Care Center, Albuquerque Metro Area, at (505) 232-1802 or outside the Albuquerque area call (800) 808-7363 ext. 1802. Lovelace Customer Care Center is available Monday through Friday, 8:00 a.m. to 5:00 p.m.

- No referrals to specialists are required.

- Unlimited prescription drug coverage is available under this Plan.

- By enrolling in this Plan, you will automatically be enrolled in the Medicare Part D prescription drug benefit and will receive all of your prescription drug benefits through this Plan. If you enroll in an individual Medicare Part D prescription drug plan, then you are not eligible for the Lovelace Senior Plan.

- You will be required to assign your Medicare benefits to the Lovelace Health Plan; therefore, you cannot be enrolled in this Plan and another Medicare Advantage Plan or another Medicare Part D plan at the same time.

- You must enroll in Medicare Parts A and B and continue to pay your Part B premium while enrolled in this plan.

- If you plan on traveling outside the service area for more than six (6) months, this Plan may not be appropriate for you because only emergency care and urgently needed care is available while you are outside the service area.

- You must inform the Lovelace Health Plan and/or Sandia Benefits before moving or leaving the service area for more than six (6) months. Your permanent residence must be in the Lovelace Senior Plan service area, which is the state of New Mexico.

- Outside the service area, this Plan covers only emergency care and urgently needed care. If you are hospitalized in a non-participating hospital for emergency care, you or a family member must call Lovelace Customer Care within 48 hours (or as soon as reasonably possible).

*If there are any discrepancies between this and the Evidence of Coverage, then the Evidence of Coverage supersedes.

Member Resources:

Lovelace Nurse Advice Line (877) 725-2552
The information line is available 24 hours a day, seven days a week, with access to a registered nurse and hundreds of medical topics.

Silver Sneakers Fitness Program:
This program offers a complimentary basic fitness center membership in certain NM cities. For more information and a list of fitness center locations, visit the web site at www.silversneakers.com.

Selecting Network Provider:
Obtain a directory by contacting Lovelace Customer Care Center, Albuquerque Metro Area, at (505) 232-1802 outside the Albuquerque area call (800) 808-7363. Lovelace Customer Care Center is available Monday through Friday, 8:00 a.m. to 5:00 p.m.

Additional Information:
For additional information on this Plan, contact Lovelace Customer Care Center at (505) 232-1802.

PRESBYTERIAN MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

The Presbyterian MediCare PPO Plan is a Medicare Advantage Plan with prescription drug benefits. This Plan is fully-insured through the Presbyterian Health Plan for eligible Medicare-primary participants who live in New Mexico.

Presbyterian MediCare PPO Key Points

Eligibility:

This Plan is available to Medicare-primary retirees, and their eligible Medicare-primary Class I dependents. Additionally, you are eligible for membership if you:

- Are entitled to Medicare Part A and are enrolled in Medicare Part B,
- Are not receiving benefits due to end-stage renal disease, and
- Continue paying your Medicare Part B premiums after joining this Plan.

Note: Class II dependents are not eligible.

IMPORTANT: You must complete the Group Medicare Advantage Plan application form and return it with your Sandia Open Enrollment Change Form. A copy of the form is included in this booklet.

Changes Effective January 1, 2010*:

In-Network:

- Urgent Care Visits from $25 copay to $10 copay
- Specialist Office Visits including Mental Health, Substance Abuse, Chiropractic and Podiatry Services from $25 copay to $30 copay
- Outpatient Services/Surgery from $75 copay to $150 copay
- Ambulance Services from $50 copay to $75 copay
- Inpatient Hospital and Mental Health Care from $250 copay to $350 copay
- Skilled Nursing Facility
  - o Days 0-20 - No change
  - o Days 21-100 from no charge to $75 copay
- Dental Services from $25 copay to $30 copay
- Hearing Services including Routine Hearing Tests from $25 copay to $30 copay
- Vision Services – Eye glasses or contact lenses after cataract surgery, routine eye exam and diagnosis and treatment of diseases and conditions of the eye from $25 copay to $30 copay

Out-of-Network:

- Specialist Office Visits including Chiropractic and Podiatry Services from $50 copay to $55 copay (Mental Health and Substance Abuse out-of-network continues to be covered at 50%)
- Dental Services from $50 copay to $55 copay
- Hearing Services including Routine Hearing Tests from $50 copay to $55 copay
- Vision Services – Eye glasses or contact lenses after cataract surgery, routine eye exam and diagnosis and treatment of diseases and conditions of the eye from $50 copay to $55 copay

Part D Prescription Catastrophic Level In-Network and Out-of-Network

From: After the member's yearly out-of-pocket drug costs reach $4,350, they pay:
- $2.25 for Generic
- the greater of $5.60 or 5% coinsurance for all others

To: After the member's yearly out-of-pocket drug costs reach $4,550, they pay:
- $2.50 for Generic
- the greater of $6.30 or 5% coinsurance for all others

Guidelines*

- Primary Care Physician (PCP) is required. Referrals to specialists are not required.
- You must inform the Presbyterian Health Plan and/or Sandia Benefits before moving or leaving the service area for more than six (6) months. Your permanent residence must be in the Presbyterian MediCare PPO service area, which is the state of New Mexico.
- You will be required to assign your Medicare benefits to the Presbyterian Health Plan; therefore, you cannot be enrolled in the Presbyterian MediCare PPO Plan and another Medicare Advantage plan or another Medicare Part D plan at the same time.
- You must enroll in Medicare Parts A and B and continue to pay your Part B premium while enrolled in this Plan.
- Both in- and out-of-network coverage is available. You may go to any Medicare-approved practitioner or provider out of network.
- Coverage is available worldwide for emergency and urgent care.

Prescription Drugs*:

- By enrolling in this Plan, you will automatically be enrolled in the Medicare Part D prescription drug benefit and will receive all of your prescription drug benefits through this Plan. You will not be required to enroll in Medicare Part D or pay the additional Medicare Part D premium.
- Unlimited outpatient prescription drug coverage is provided through the Presbyterian network of pharmacies. This network has over 48,000 contracted pharmacies nationwide.
- Covered drugs under the Presbyterian MediCare PPO Plan may have requirements or limits on coverage such as prior authorization, quantity limits, or step therapy. The Prescription Drug Formulary list of covered drugs will identify the requirements or limits.
- The Presbyterian Health Plan may make changes to their formulary during the year. The Presbyterian Health Plan will notify members when a drug is removed from the formulary, prior authorization is added, quantity limits and/or step therapy restriction are placed on a drug, or if a drug is moved to a higher cost-sharing tier.
- To get updated information about the drugs covered by this Presbyterian MediCare PPO, please visit the Presbyterian website at www.phs.org or call Member Services at (505) 923-6060 or toll free (800) 797-5343, Monday through Friday, 7 a.m. to 6 p.m. TTY/TDD users should call (888) 625-8818.

*If there are any discrepancies between this and the Evidence of Coverage, then the Evidence of Coverage supersedes.

Member Resources:

Presbyterian MediCare Member Services (800) 797-5343
Access to member services representatives, 8 a.m. to 8 p.m., seven days a week

Nurse Advice Line (800) 887-9917
Access to a 24-hour nurse advice line

Healthy Living Programs
Access to health and wellness education such as classes and internet health links, including access to a health risk assessment to identify health habits you can improve, learn about healthful lifestyle techniques, and access health improvement resources.

Presbyterian Health Services (PHS) Programs and Hospital Services
Many specialty programs are available, including the Arthritis Center, Heart Center, Senior Services and more.

A.D.A.M. www.adam.com
A.D.A.M. provides you with a wealth of illustrated health information that simplifies complex health and medical topics. There are more than 10,000 pages of text-based information; 40,000 medical illustrations; 3D computer models; thousands of animations; and interactive tools.

To learn more about these programs, go to www.phs.org or call (800) 979-5343.

Selecting a Network Provider:
You can obtain a directory through the online provider directory at www.phs.org or by calling Presbyterian MediCare PPO Member Services at (800) 979-5343.

Additional Information:
For additional information on this Plan, refer to the Presbyterian MediCare Preferred Provider Organization Plan document at http://www.sandia.gov/benefits/spd/pdfs/, and the Retiree Medical Plans Comparison Chart.

KAISER PERMANENTE TRADITIONAL PLAN

The Kaiser Permanente Traditional Plan is an HMO plan with prescription drug benefits. This Plan is fully-insured through Kaiser Permanente for eligible Pre-Medicare participants who live in California, within designated service areas.

Kaiser Permanente Traditional Plan Key Points

Eligibility:

This Plan is available to the following who live within a Kaiser-designated service area (currently, Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus counties are entirely inside a Kaiser service area; service areas for other Northern California counties are determined by specific ZIP codes within those counties).

This plan is available to Pre-Medicare retirees, and their Pre-Medicare Class I dependents (dependents of eligible Class I dependents may also be eligible).

Class II dependents are not eligible.

Changes Effective January 1, 2010:

- **Behavioral Health Benefits**

Mental Health Inpatient

- o Maximum of 45 days per calendar year no longer applies

Mental Health Outpatient

- o Maximum of 20 visits per calendar year no longer applies

Guidelines:

- Offers integrated health care with one stop access to medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Kaiser Permanente providers and facilities must be used. If you access care outside the Kaiser Permanente network, your services may not be covered, except for emergency, urgent care and Kaiser coordinated out-of-network services.
- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- You must reside within a Kaiser Permanente service area to be eligible for the Plan and may only leave the service area for a maximum of 90 continuous days. Exception: Students attending school outside the service area
- Coverage is available worldwide for emergency and urgent care.

Member Resources:

Member Services Call Center
(800) 464-4000
Kaiser member services is available weekdays, 7 a.m. to 7 p.m., and weekends, 7 a.m. to 3 p.m.

Nurse Advice Line
Provides access to a 24-hour nurse advice line available 24 hours a day, seven days a week. You can find your region's nurse advice line through the Kaiser Your Guidebook provided to new members, or call (800) 464-4000 to locate your region's nurse advice line resource phone number.

Comprehensive Website www.kponline.org
Provides members the ability to make appointments, consult an advice nurse or pharmacist, on-line health assessment, health-care information, customized online health improvement programs, and more.

Health and Wellness
Health education in the form of videos, reading materials, and free take-home literature are available at every Kaiser Permanente facility. In addition, Kaiser offers a wide variety of health education classes on topics such as first aid/ accident prevention, nutrition, smoking cessation, and stress reduction.

Chiropractic Benefit - American Specialty Health Plans of CA (800) 678-9133
Provides direct access to American Specialty Health Plans (ASH) network of participating chiropractors. To learn more about the ASH providers, visit the website at www.ashcompanies.com.

Healthyroads www.healthyroads.com
An innovative health improvement program that helps you take charge of your health through a variety of online tools, including a personal health assessment and a customized exercise planning program. To learn more about the discounts available, go the Healthyroads website.

Additional Information:
For additional information on this Plan, refer to the Kaiser Traditional HMO Plan Evidence of Coverage and Kaiser Chiropractic Evidence of Coverage at http://www.sandia.gov/resources/emp-ret/spd/index.html, and the Retiree Medical Plans Comparison Chart.

KAISER SENIOR ADVANTAGE PLAN (KPSA)

The Kaiser Senior Advantage Plan is a Medicare Advantage Plan with prescription drug benefits. This Plan is fully-insured through Kaiser Permanente for eligible Medicare-primary participants who live in California, within Kaiser-designated service areas.

Kaiser Senior Advantage Plan Key Points

Eligibility:

This Plan is available to the following who live within a Kaiser-designated service area (currently, Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus counties are entirely inside a Kaiser service area; service areas for other Northern California counties are determined by specific ZIP codes within those counties).

This plan is available to Medicare-primary retirees, and their Medicare-primary Class I dependents.

Note: Class II dependents are not eligible.

IMPORTANT: You must complete the California Kaiser Group Plan Medicare Advantage Universal Enrollment/Election Form and return it with your Sandia Open Enrollment Change Form. A copy of the form is included in this booklet.

Changes Effective January 1, 2010:

- **Behavioral Health Benefits**
  Mental Health Inpatient
  - o Maximum of 45 days per calendar year no longer applies

  Mental Health Outpatient
  - o Maximum of 20 visits per calendar year no longer applies

Guidelines:

- Integrated health care with one stop access to medical offices, specialty offices, laboratory, pharmacy, and optical services at each facility.
- Kaiser Permanente providers and facilities must be used. If you access care outside Kaiser Permanente, your services may not be covered, except for emergency and urgent care.
- Self-referral to selected specialty departments; others require a referral from your Plan physician.
- You must reside within a Kaiser Permanente service area to be eligible for the Plan and may only leave the service area for a maximum of 90 continuous days. Exception: Students attending school outside the service area
- Coverage is available worldwide for emergency and urgent care.
- Medicare benefits must be assigned to Kaiser Permanente. Therefore, you cannot be enrolled in another Medicare Advantage Plan or Medicare Part D Plan at the same time you are enrolled in Kaiser Senior Advantage Plan.
- When you select Senior Advantage, your regular Medicare benefits are provided by Kaiser Permanente. You must maintain your Medicare Parts A and B enrollment in order to keep your Senior Advantage coverage.

- When you select Senior Advantage, you will automatically be enrolled in a Medicare Part D prescription drug benefit. You will receive all of your prescription drugs through the Senior Advantage Plan and pay the Senior Advantage prescription drug copays based upon the specific drug and quantity prescribed. You will not be required to pay the additional Medicare Part D premium to Medicare or the Senior Advantage Plan.

- Medicare will not pay for any medical care you receive from a non-Kaiser Permanente health care provider unless you have been referred to the outside provider by a Kaiser Permanente physician. When you enroll in Senior Advantage, you agree to receive all your medical services through Kaiser Permanente, except for emergencies, urgent out-of-area care, or authorized referrals.

- Senior Advantage is designed for people who live in the Kaiser Permanente service area. If you plan to leave the service area for more than 90 days or move permanently outside the service area, you must disenroll from Senior Advantage.

Member Resources:

Member Services Call Center
(800) 464-4000
Kaiser member services is available weekdays, 7 a.m. to 7 p.m., and weekends, 7 a.m. to 3 p.m.

Nurse Advice Line
Provides access to a 24-hour nurse advice line available 24 hours a day, seven days a week. You can find your region's nurse advice line through the Kaiser Your Guidebook provided to new members, or call (800) 464-4000 to locate your region's nurse advice line resource phone number.

Comprehensive Website
www.kponline.org
Provides members the ability to make appointments, consult an advice nurse or pharmacist, on-line health assessment, health-care information, customized online health improvement programs, and more.

Health and Wellness
Health education in the form of videos, reading materials, and free take-home literature are available at every Kaiser Permanente facility. In addition, Kaiser offers a wide variety of health education classes on topics such as first aid/ accident prevention, nutrition, smoking cessation, and stress reduction.

Chiropractic Benefit - American Specialty Health Plans of CA (800) 678-9133
Provides direct access to American Specialty Health Plans (ASH) network of participating chiropractors. To learn more about the ASH providers, visit the website at www.ashcompanies.com.

Healthyroads www.healthyroads.com
An innovative health improvement program that helps you take charge of your health through a variety of online tools, including a personal health assessment and a customized exercise planning program. To learn more about the discounts available go the Healthyroads website.

Additional Information:
For additional information on this Plan, refer to the Kaiser Senior Advantage Plan Evidence of Coverage and Kaiser Chiropractic Evidence of Coverage at http://www.sandia.gov/resources/emp-ret/spd/index.html, and the Retiree Medical Plans Comparison Chart.

MEDICAL PREMIUM SHARING

Monthly Premiums Effective January 1, 2010

Employees Who Retired Prior to January 1, 1995

Employees who retired prior to January 1, 1995, will not be required to pay a premium share for themselves or any eligible Class I dependents at this time. (Exception: Retirees who retired prior to January 1, 1995, but who currently pay a portion of their medical coverage will continue to do so.)

Employees Who Retired After December 31, 1994, and Before January 1, 2003

All employees who retired after December 31, 1994, pay a monthly premium for coverage in Sandia's medical plans. The monthly premium share amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Table A to find your rate for your selected plan(s).

Employees Who Retired After December 31, 2002

Employees who retired after December 31, 2002, pay a percentage of the full premium based on years of service. The monthly premium share amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Tables B through F to find your rate for your selected plans(s).

Non-Represented Employees Who Hired (or Rehired), and Retired after December 31, 2008

Represented OPEIU Employees Who Hired (or Rehired) and Retired after July 1, 2009

Represented MTC Employees who Hired (or Rehired) and Retired after July 1, 2010

Employees who hired (or rehire) and retired as stated above, pay the full medical premium. The monthly premium amount will be deducted from your pension check. Rates will vary according to your plan choice(s). Use Table F if you hired and retired as stated above.

Class II Dependents:

- Class II dependents for whom you currently pay a Class II premium will not be counted as dependents in calculating the premiums stated above.

- Any Class II dependents for which you do not pay the full Class II premium will be counted as dependents for premium sharing in the calculation.

The monthly premium for a Pre-Medicare Class II dependent is:

- $533.40 for the UnitedHealthcare Premier PPO Plan

The monthly premium for a Medicare Class II dependent is:

- $214.90 for the UnitedHealthcare Senior Premier PPO Plan

The monthly premium for a Pre-Medicare Class II dependent is:

- $494.90 for the Sandia Total Health

Table A (Retired after 12/31/1994 and before 1/1/03 OR after 1/1/03 with 30+ years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$31	$17	$7	$27
2	$61	$34	$14	$54

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$71	$76	$79	$61
2	$142	$152	$159	$121
3	$212	$229	$238	$172

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	Presbyterian MediCare PPO[2] / Sandia Total Health[2]	UHC Senior Premier PPO / UHC Premier PPO	Presbyterian MediCare PPO[3] / UHC Premier PPO	Lovelace Senior Plan[2] / CIGNA In-Network Plan	Kaiser Senior Advantage Plan / Kaiser Permanente Traditional HMO
1	1	$88	$107	$93	$86	$88
2	1	$105	$138	$110	$93	$115
1	2	$159	$183	$170	$166	$148

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Presbyterian MediCare with Sandia Total Health, and Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in these combination plans.

Table B (Employees who retired after 12/31/2002 with 25-29 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$46	$26	$11	$40
2	$92	$51	$20	$81

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$106	$114	$119	$91
2	$212	$229	$238	$182
3	$318	$343	$357	$258

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	Presbyterian MediCare PPO[2] / Sandia Total Health[2]	UHC Senior Premier PPO / UHC Premier PPO	Presbyterian MediCare PPO[3] / UHC Premier PPO	Lovelace Senior Plan[2] / CIGNA In-Network Plan	Kaiser Senior Advantage Plan / Kaiser Permanente Traditional HMO
1	1	$132	$160	$140	$130	$132
2	1	$157	$206	$166	$140	$172
1	2	$238	$275	$254	$249	$223

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Presbyterian MediCare with Sandia Total Health, and Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in these combination plans.

Table C (Employees who retired after 12/31/2002 with 20-24 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$77	$43	$18	$67
2	$154	$86	$35	$135

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$177	$191	$199	$152
2	$354	$381	$397	$303
3	$531	$572	$595	$429

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	Presbyterian MediCare PPO[2]	UHC Senior Premier PPO	Presbyterian MediCare PPO[3]	Lovelace Senior Plan[2]	Kaiser Senior Advantage Plan
		Sandia Total Health[2]	UHC Premier PPO	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	1	$220	$267	$233	$216	$219
2	1	$262	$344	$276	$234	$287
1	2	$397	$458	$424	$414	$371

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Presbyterian MediCare with Sandia Total Health, and Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in these combination plans.

Table D (Employees who retired after 12/31/2002 with 15-19 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$107	$60	$25	$94
2	$215	$120	$49	$189

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$247	$267	$278	$212
2	$495	$533	$555	$425
3	$743	$800	$833	$601

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	Presbyterian MediCare PPO[2]	UHC Senior Premier PPO	Presbyterian MediCare PPO[3]	Lovelace Senior Plan[2]	Kaiser Senior Advantage Plan
		Sandia Total Health[2]	UHC Premier PPO	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	1	$307	$374	$327	$302	$307
2	1	$367	$482	$386	$327	$401
1	2	$555	$641	$593	$580	$519

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Presbyterian MediCare with Sandia Total Health, and Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in these combination plans.

Table E (Employees who retired after 12/31/2002 with 10-14 years)

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO[1]	Lovelace Senior Plan[1]	Kaiser Senior Advantage Plan[1]
1	$138	$77	$32	$121
2	$276	$154	$63	$243

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$318	$343	$357	$273
2	$637	$686	$714	$546
3	$955	$1,029	$1,071	$773

Mixed Medicare and Non-Medicare Family (your family has both Medicare-primary and non-Medicare-primary members)

Medicare	Non-Medicare	Presbyterian MediCare PPO[2]	UHC Senior Premier PPO	Presbyterian MediCare PPO[3]	Lovelace Senior Plan[2]	Kaiser Senior Advantage Plan
		Sandia Total Health[2]	UHC Premier PPO	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	1	$395	$481	$420	$389	$395
2	1	$472	$619	$497	$420	$516
1	2	$714	$824	$763	$746	$668

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval.

[2]The combination Presbyterian MediCare with Sandia Total Health, and Lovelace Senior Plan with CIGNA In-Network Plan is available for new enrollment.

[3]The combination Presbyterian MediCare with UHC Premier is no longer available for new enrollment. These rates apply only to **previous** retirees enrolled in these combination plans.

Table F (Employee that hired (or rehired) and Retired based on the following:)

Non-Represented Employees Who Hired (or Rehired) and Retired after December 31, 2008
Represented OPEIU Employees Who Hired (or Rehired) and Retired after July 1, 2009
Represented MTC Employees who Hired (or Rehired) and Retired after July 1, 2010

Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$307	$171	$70	$269.81
2	$614	$342	$140	$539.62

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$707	$762	$794	$606.98
2	$1,415	$1,524	$1,587	$1,213.96
3	$2,122	$2,286	$2,381	$1,717.76

SURVIVING SPOUSE MEDICAL PLAN PREMIUM SHARING

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2010

Effective January 1, 2010, Sandia no longer offers a 6 month premium share grace period for the first six months. The surviving spouse (and any dependents enrolled at the time of death) may continue coverage by paying:

- 50 percent of the full experience-rated premium if you are a survivor of a retiree or a regular employee with more than 15 years of service (based on term of employment).
- 100 percent of the full experience-rated premium if you are a survivor of a retiree or a regular employee with less than 15 years of service (based on term of employment)
- 100 percent of the full experience-rated premium if you are the survivor of a non-represented employee who hired or rehired in after December 31, 2008; OPEIU represented who hired or rehired in after June 30, 2009; MTC represented who hired or rehired in after June 30, 2010

Important: If you are a surviving spouse and you waive or drop coverage, you can never reenroll in a Sandia-sponsored medical plan.

Note: If you remarry, you are no longer eligible for a Sandia-sponsored medical plan.

Surviving spouse of a retiree or regular employee with more than 15 years of service
Medicare Family (everyone in your family is Medicare-primary)

Number of Medicare	UHC Senior Premier PPO	Presbyterian MediCare PPO	Lovelace Senior Plan	Kaiser Senior Advantage Plan
1	$153.50	$85.50	$35	$134.91

Non-Medicare Family (no one in your family is Medicare-primary)

Number of Non-Medicare	Sandia Total Health	UHC Premier PPO	CIGNA In-Network Plan	Kaiser Permanente Traditional HMO
1	$353.50	$381	$397	$303.49
2	$707.50	$762	$793.50	$606.98

[1]Rates for Presbyterian MediCare PPO Plan, the Lovelace Senior Plan, and the Kaiser Senior Advantage Plan are subject to change based on Centers for Medicare and Medicaid (CMS) approval

Administration of Surviving Spouse medical coverage is managed by UnitedHealthcare Business Services.

UnitedHealthcare Business Services
(866)747-0048 - www.uhcservices.com - Business Hours: 8:00am to 8:00pm Eastern Time

DENTAL CARE PROGRAM

Sandia Dental Care Program is administered by Delta Dental of Michigan

Eligibility for Dental Care Plan:

This Plan is available to retired employees and their eligible dependents.

Highlights:

- Effective January 1, 2010, Delta Dental will issue identification cards under the primary subscriber with a unique identification number. The ID card only lists the primary covered member and the alternate ID number is just one number that all family members use. One card will be issued for single and two cards per family, additional cards can be ordered through the toolkits website (noted below).
- Coinsurance coverage based on a percentage of the maximum approved fee for the following types of services:
- Basic and restorative services that include fillings, extractions, endodontic and periodontal services will be covered at 80%
- Major services such as crowns, prosthodontics, and specified implant procedures will be covered at 50%
- Orthodontic services will be covered at 50%
- Preventive services such as oral examinations, routine cleanings, and x-rays will be covered at 100%
- Annual deductible of $50 per individual up to a family annual maximum deductible of $150
- Annual maximum benefit for non-orthodontic covered services is $1500
- Lifetime maximum benefit for orthodontic covered services is $1800

Member Resources:

Delta Dental Consumer Toolkit
http://www.toolkitsonline.com
Allows members to check benefits, eligibility, claims information, print ID cards and find a provider.

Additional Information:
For additional information on this Plan, refer to the Dental Care Program summary at http://www.sandia.gov/resources/emp-ret/spd/index.html

DENTAL CARE PLAN PREMIUMS

Monthly Premiums Effective January 1, 2010

Employees Who Retired Prior to January 1, 2009

Employees who retired prior to January 1, 2009, will not be required to pay a dental premium share for themselves or any eligible Class I dependents at this time.

Employees Who Hired Prior to January 1, 2009, and Retired after December 31, 2008

Employees who hired prior to December 31, 2008 and retired on or after January 1, 2009, pay a monthly dental premium share. The monthly premium amount will be deducted from your pension check. Rates are based on retiree, retiree plus one, or retiree plus three or more eligible dependents. Use the table below to find your rate for the Dental Care Program.

Family Count	Dental Care Plan
Retiree Only	$8.00
Retiree + 1	$16.00
Retiree + 2 or more	$22.00

Non-Represented Employees Who Hired (or Rehired) and Retired after December 31, 2008

Represented OPEIU Employees Who Hired (or Rehired) and Retired after July 1, 2009

Represented MTC Employees who Hired (or Rehired) and Retired after July 1, 2010

Employees who hired and retired as stated above, pay the full monthly dental premium. The monthly premium amount will be deducted from your pension check. Rates are based on retiree, retiree plus one, or retiree plus three or more eligible dependents. Use the Table below to find your rate for the Dental Care Program.

Family Count	Dental Care Plan
Retiree Only	$42.00
Retiree + 1	$82.00
Retiree + 2 or more	$108.00

RETIREE MARRIED TO ACTIVE SANDIAN/OTHER RETIREE

During Open Enrollment, you may elect to cover yourself as

1) an individual or

2) a dependent of your Sandia spouse or

3) the primary covered retiree/employee with your Sandia spouse as a dependent, regardless of your/their salary tier or medical plan choice. Monthly premiums will be based on the primary Sandia participant.

Note: If you are Medicare-eligible, different rules with respect to Medicare apply, depending on if you are covered as the primary participant, an individual, or a dependent of an active Sandian. Call the HBE Customer Service at (505) 844-HBES (4237) for more information.

If you and your Sandia spouse elect to be covered separately, any eligible dependents may be covered under either spouse (e.g., enroll some dependents under one spouse and others under the other spouse, etc.).

Important: No one (employees or eligible dependents) may be covered as both a primary participant and a dependent, or as a dependent under two different Sandia employees/retirees.

If you wish to change your coverage for 2010, both Sandians must do so by completing the Open Enrollment Change Form included in this booklet and returning it by November 10, 2009 (must be postmarked by November 10).
The primary covered retiree/employee must enroll his or her spouse and any other dependents by using the Open Enrollment Change Form.

ELIGIBILITY GUIDELINES FOR RETIREES

Eligibility for Coverage under the UnitedHealthcare (UHC) Premier PPO Plan, Presbyterian MediCare PPO Plan, CIGNA In-Network Plan, Lovelace Senior Plan, UHC Senior Premier PPO Plan, Sandia Total Health, and Dental Care Plan.

If you are the primary member under the Plan, your Class I dependents eligible for membership include your:

- Spouse, not legally separated or divorced from you,
- Unmarried dependent child[1] under age 24,
- Unmarried child of any age
  - o who is permanently and totally disabled* and is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months,
  - o who lives with you, in an institution or in a home that you provide,
  - o and who is "financially dependent" on you.

  Note: The claims administrator determines if the applicant is disabled. Please contact Sandia's Benefits Customer Service Center at (505) 844-HBES (4237) for more information on enrolling your child as an incapacitated dependent.
- Unmarried child who is recognized as an alternate recipient in a "qualified national medical support order" (QNMSO) enforceable with respect to Sandia's plan.

[1]Child includes:

- the primary covered member's own children and legally adopted children
- adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to Sandia Benefits
- unmarried stepchild of the primary covered member who lives with you at least 50% of the calendar year, or if ages 19 through 23 is a full time student

  Note: Unmarried step children 19-23 can take a medically necessary leave of absence and continue coverage under the Sandia plan for up to 12 months (unless the child's eligibility would end earlier for another reason).
- child for whom the primary covered member has legal guardianship
- natural child, legally adopted child, or child for whom the primary covered member has legal guardianship if a court decree requires the primary covered member to provide coverage

Eligibility for coverage under the Kaiser Permanente Traditional HMO and the Kaiser Permanente Senior Advantage Plan have the same eligibility requirements as stated above, however, they also include:

- other unmarried dependent persons who meet all of the following requirements (excluding foster children):
- He or she is under age 24,

- He or she receives from you or your spouse all of his or her support and maintenance,
- He or she permanently resides with you (the primary member),
- You or your spouse is the court-appointed guardian (or was before the person reached age 18), or whose parent is an enrolled dependent under your family coverage.

*Kaiser Permanente disabled dependent requires the following additional requirements:

- The dependent is incapable of self-sustaining employment because of mental retardation or physical handicap that occurred **prior to reaching the age limit for dependents**
- Receive substantially all of their support and maintenance from you and your spouse
- You give Kaiser proof of their incapability within 31 days after Kaiser requests it

  Note: Kaiser Permanente determines if the applicant is disabled.

Class II Dependents

No additional Class II Dependents can be enrolled in any of the Sandia medical plans.

To continue to qualify for medical coverage, a Class II dependent must:

- Be "financially dependent" on you; financially dependent means that a person receives greater than 50% of their financial support for the calendar year from the primary member,
- Have a total income from all sources of less than $15,000/year other than the support you provide, and
- Have lived in your home, or one provided by you in the United States, for the most recent six months.

  Note: Class II Dependent annual recertification is required.

Important Notice Regarding Tax Treatment of Benefits for Dependents

The requirements and criteria below are **independent** of the Sandia health plan eligibility criteria. Retirees are completely responsible for evaluating each dependent to insure they comply with the federal tax law requirements. In the event of an IRS audit, the employee (not Sandia) is ultimately liable for any findings associated to the audit.

In making your annual benefit elections, please be aware that the Federal tax law **may cause some benefits to be taxable in certain circumstances.** The Working Families Tax Relief Act of 2004 ("WFTRA") defines two types of dependents for the purposes of health care coverage in the Internal Revenue Code – a "qualifying child" and a "qualifying relative." There are different requirements for each dependent as follows:

To have a dependent status as a "qualifying child", the individual must:

- share the taxpayer's residence for more than half the year,
- be the taxpayer's child, stepchild, sibling, step-sibling or any of the descendants of these relatives; for example, a grandchild, niece or nephew (adopted and qualified foster children are considered the taxpayer's children);

- be under age 19, or under age 24 in the case of a full-time student on the last day of the tax year (no age limit applies to any of the listed individuals if they are totally and permanently disabled); and

- not provide more than half of his or her own support

To have a dependent status as a "qualifying relative", the individual must:

- receive over half of his or her support from the taxpayer,

- not be a "qualifying child" dependent of the taxpayer or any other taxpayer,

- be the taxpayer's child, sibling, step-sibling or any of their descendants; a parent or stepparent or any of their ancestors; an aunt, uncle, niece, or nephew; children-or parents-in-law; or an unrelated individual who shares the taxpayer's residence as a member of their household

Although Congress apparently did not intend the WFTRA to affect the tax treatment of benefits provided to dependents of employees and retirees, in some circumstances, medical benefits may be taxable. We understand that these requirements are confusing. It is important to contact your tax advisor if you have any questions about how these changes may affect you. If your dependent does not meet the "qualifying child" or "qualifying relative", please contact Sandia HBES, so the Benefits department can impute income on any premiums as applicable.

Ineligible Dependents

You must disenroll your ineligible dependents within 31 calendar days. For example, the following lists events that would make your dependents ineligible.

Class I Dependents

- Divorce or annulment

- Legal separation

- Child marries

- Child reaches age 24

- Incapacitated child no longer meets incapacitation criteria

Class II Dependents

- Child, step-child, grandchild, brother or sister marries

- Child, step-child, grandchild, brother, sister, parent, step-parent or grandparent no longer meets Class II eligibility requirements criteria

ENROLLING AND DISENROLLING DEPENDENTS FOR MEDICAL AND DENTAL COVERAGE

If you want to add a dependent to your coverage, you must do so during Open Enrollment. You can only add a dependent to your coverage outside of Open Enrollment based on an eligible mid-year election change event (e.g., marriage, birth, adoption). If you add a dependent during Open Enrollment, coverage will become effective January 1, 2010.

Disenrolling Ineligible Dependents

You must disenroll any dependent that is no longer eligible for plan coverage within 31 days of becoming ineligible.

You can drop a dependent at any time during the plan year. If a dependent becomes ineligible during the plan year, you must disenroll the dependent within 31 calendar days of the mid-year election change event causing ineligibility. If you fail to disenroll your dependent within 31 calendar days, see section entitled "Consequences of Not Meeting the Disenrollment Requirements."

Note: If you drop a dependent, you can re-enroll eligible dependents during Open Enrollment for coverage effective the following calendar year, or within 31 calendar days of an eligible mid-year election change event.

To add/drop a dependent, you must complete the Open Enrollment Change Form included in this booklet. It must be postmarked by November 10, 2009.

Consequences of Not Meeting the Disenrollment Requirements

- Sandia will take action that results in permanent loss of health plan coverage for you and your dependents for fraudulent use of the Plan.
- Sandia will report the incident to the office of the Inspector General.
- Sandia will retroactively terminate dependent coverage, effective the end of the month in which the dependent became ineligible.
- Sandia is not liable to refund any applicable monthly premiums paid by you during the ineligible period.
- You will be personally liable to refund to Sandia all health care plan claims and/or premiums rendered during the ineligible period.
- Your dependent could lose any rights to temporary, continued health care coverage under COBRA.

IMPORTANT BENEFIT NOTICE

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy and requires employers to inform health plan participants annually about this Act. Under WHCRA, group health plans offering mastectomy coverage must also provide certain services relating to the mastectomy. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for the following:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your medical plan.

MEDICAL PLAN DEFINITIONS

Balance Billing
In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge is known as balance billing. The balance billing amount is the difference between Medicare's allowed charge and the provider's actual charge to the patient.

Billed Charges
The amount the provider bills for a service

Centers of Excellence
A special Plan network that provides members and their families with access to medical care at some of the most well-known and respected health care institutions in the United States for technologically advanced procedures including organ transplants, cancer resource services, and congestive heart disease services.

Claims Administrator
The third party designated by Sandia to receive, process, and pay claims according to the provisions of the Plan.

CMS
Center for Medicare and Medicaid Services

Coinsurance
Cost-sharing feature by which both the Plan and the covered member pay a percentage of the covered charge

C.O.B. (Coordination of Benefits)
When a covered member has medical coverage under other group health plans (including Medicare), the Plan benefits are reduced so that total combined payments from all plans do not exceed 100% of the Eligible Expense

Copayment/Copay
Cost-sharing feature by which the Plan pays the remainder of the covered charge after the covered member pays his or her portion as a defined dollar amount

Cost-sharing Liability
Cost-sharing is the portion of payment to a provider of health care services that is the liability of the patient. Cost-sharing liabilities include deductibles, copayments, coinsurance, and balance billing amounts.

Covered Charge or Covered Expense
Any expense covered by the Plan during a claim period

Creditable Prescription Drug Coverage
Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage

Deductible
Covered charges incurred during a calendar year that the covered member must pay in full before the Plan pays benefits (with the exception of prescription drugs and certain preventive benefits in-network).

Dual Sandians
Both spouses are employed by and/or retired from Sandia National Laboratories

Durable Medical Equipment (DME)
Equipment determined by the Plan to meet the following criteria:
- is prescribed by a licensed physician
- is medically appropriate

- is not primarily and customarily used for a non-medical purpose
- is designed for prolonged use, and
- serves a specific therapeutic purpose in the treatment of an injury or sickness

Eligible Expenses
(for the UHC plans, formerly referenced as U&C) Charges for Covered Health Services that are provided while the plan is in effect, determined as follows for out-of-network benefits:
- Negotiated rates agreed to by the out-of-network provider and either the Claims Administrator or one of its vendors, affiliates, or subcontractors
  - The following:
  - Selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area;
  - Fees that are negotiated with the provider;
  - XX% of the billed charge; or
  - A fee schedule that the Claims Administrator develops.

E.O.B. (Explanation of Benefits)
A statement detailing the medical benefits accounts activity for an individual or family.

Health Maintenance Organization (HMO)
A corporation financed by insurance premiums whose member physicians and professional staff provide curative and preventive medicine within certain financial, geographic, and professional limits to enrolled volunteer members and their families.

Health Reimbursement Account (HRA)
Internal Revenue Service (IRS)-sanctioned program that allow an employer to reimburse medical expenses paid by participating employees.

In-Network
Services that are provided by a Health Care Provider that is a member of the claim administrators network.

Inpatient Stay
An uninterrupted confinement of at least 24 hours following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility

Long-Term Care
A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare and Sandia medical plans don't pay for this type of care if this is the only kind of care you need.

Maintenance Care
Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as nonsurgical spinal treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.

Medicaid
A joint Federal and State program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Allowable
See "Medicare Approved Amount"

Medicare Approved Amount
In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount charged by a doctor or supplier; amount Medicare approves for this service or supply.

Medicare Assignment
In the Original Medicare Plan, this means a doctor or supplier agrees to accept the Medicare-approved amount as full payment.

Negotiated Fees
A contractual fee agreed to by providers or facilities and the Claims Administrator for services provided to PPO plan members.

Network Gap Exception (UHC Only)
If there are no in-network providers in the required specialty within a 30-mile radius from the covered member's home, the Plan may grant an exception to allow in-network benefits for services provided by an out-of-network provider.

Non-Preferred Drug
A drug not included on the plan administrator prescription preferred drug list selected as a generic or preferred drug; any preferred name drug for which a generic product becomes available may be designated as a non-preferred product (higher copayment)

Open Enrollment
The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year)

Out-of-Area Plan
Members who do not have access to Plan network providers within a 30-mile radius of their home will be covered under the in-network level of benefits under the out-of-area plan when they access providers. Reimbursement is based on billed charges.

Out-of-Network
Services provided by a Health Care Provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO

Out-of-Pocket Maximum
The member's financial responsibility for covered medical expenses before the Plan reimburses additional covered charges at 100% for the remaining portion of that calendar year (outpatient prescription drugs and pre-Medicare office visit copays do not apply to the out of pocket maximum).

Participating Provider
The health care professionals, hospitals, facilities, institutions, agencies, and practitioners with whom the Plan contracts to provide covered services and supplies to Plan participants

Penalty
An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan (Part D), if you don't join when you are first eligible. You pay this higher amount as long as you have Medicare. There are some exceptions.

Plan Administrator
Sandia National Laboratories

Precertification (see Prior Notification)

Pre-Determination
Process by which the member determines if a service is covered under the Sandia benefit plan.

Detailed information is submitted to the health Plan by the physician or member to ensure a complete review.

Preferred Drug
A drug included on the plan administrator preferred drug list selected according to the drug safety, efficacy, therapeutic merit, current standard of practice and cost

Preferred Provider Organization (PPO)
A network of physicians and other health care providers who are under contract to provide services for a negotiated fee

Preventive Services
Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and certain cancer screenings).

Primary Care Doctor (PCP)
A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Prior Notification (also known as Pre-certification or Prior Authorization)
The process where the covered member calls the claims administrator to obtain prior approval for certain medical services or procedures.

Service Area
The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to covered members

Skilled Nursing Facility Care
This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy.

The need for custodial care (such as help with activities of daily living, like bathing and dressing) cannot qualify you for Medicare coverage in a skilled nursing facility if that's the only care you need. However, if you qualify for coverage based on your need for skilled nursing care or rehabilitation, Medicare will cover all of your care needs in the facility, including help with activities of daily living.

Usual & Customary (U&C) Charges
(UHC see Eligible Expenses)
Based on the range of fees charged by physicians, health care facilities, or other health care providers in the same geographical area for the same or similar services. CIGNA HealthCare has the exclusive right to determine the usual and customary charges.

OPTION TO WAIVE MEDICAL COVERAGE

You have the option to waive medical coverage for yourself and any dependents. Please review your alternate insurance coverage prior to making your decision to waive your coverage through Sandia's plan. Coverage for any eligible dependents is based on your coverage as a Sandia retiree; therefore, if you waive medical coverage for yourself, you are also waiving coverage for all dependents. If you waive medical coverage, the next opportunity to re-enroll will be the next annual Open Enrollment.

If you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.

You must complete the Waiver of Medical Coverage Form included in this booklet and it must be received by the Benefits Department by November 10, 2009. If you do not actively waive your medical coverage in Sandia's plan, you are thereby giving authorization to Sandia to deduct the appropriate premium from your pension check beginning January 1, 2010.

Dropping Medical Coverage:

Because you pay premiums on an after-tax basis, you can drop medical coverage for yourself and your dependents at any time throughout the calendar year without an eligible mid-year election change event, with written notification to the Benefits Department, MS 1463.

2010 Open Enrollment Appeals

Retiree election changes after November 10 will only be considered due to the following: if it is determined the enrollee experienced extenuating circumstance(s) (e.g., international/remote travel or medical emergency for yourself or immediate family member) to support the enrollment request after November 10, 2009. Failing to make your elections because you forgot or did not take the time, is not considered "extenuating circumstances."

If you believe you have experienced extenuating circumstances to support an enrollment change, contact HBES Customer Service (505) 844-HBES (4237) by December 4, 2009.

Waiver of Medical Coverage Form

To waive medical coverage for yourself and your dependents, you must fill out the information requested below and return it to the Benefits Customer Service Center at MS 1463 or Fax: (505) 844-7535. (If mailing from outside Sandia, please see complete address below.) This form must be received by the Benefits Department by November 10, 2009.

I, _____, SSN: _____ waive coverage for myself and all dependents in any of Sandia's medical plans effective January 1, 2010.

I understand the benefit I am waiving and that Sandia is not responsible for any medical expenses incurred by me and/or my dependents during the period in which these benefits are waived.

I also understand that my next opportunity to re-enroll in a Sandia medical plan will be during the Open Enrollment period for the next calendar year or based on an eligible mid-year election change event.

_____ _____

Retiree Date

Sandia National Laboratories
PO Box 5800
Albuquerque, New Mexico 87185-1463
Attn: Benefits Customer Service Department, MS 1463

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SANDIA NATIONAL LABORATORIES' DISCLOSURE OF MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Sandia National Laboratories About Your Prescription Drug Coverage and Medicare for 2010

This notice has information about your current prescription drug coverage with Sandia National Laboratories and prescription drug coverage available for people with Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. **Please read this notice carefully and keep it where you can find it.**

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Sandia National Laboratories has determined that the prescription drug coverage offered by the Sandia Total Health, UnitedHealthcare (UHC) Premier PPO, the CIGNA In-Network, the Kaiser HMO, and the UHC Senior Premier PPO is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

   Note: If you enroll in the Presbyterian MediCare PPO Plan, the Lovelace Senior Plan or the Kaiser Permanente Senior Advantage Plan for 2010, you will automatically be enrolled in the new Medicare Part D prescription drug benefit through the Plan and will receive all of your prescription drugs through the plan you selected. This Notice does not apply to those enrolled in these Plans.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

Your current medical coverage through Sandia National Laboratories pays for other health expenses in addition to prescription drug. If you and/or your dependents enroll in a Medicare drug plan, you and/or your dependents will still be eligible to receive medical and prescription drug benefits. If you and/or your dependents enroll in a Medicare drug plan, in general, the following guidelines listed below apply. (**Note:** There are exceptions for Medicare domestic partners of employees as well as those plan participants who have End Stage Renal Disease. Please contact Sandia HBE at the number listed below for more information.)

If you are an active employee and are enrolled in the Sandia Total Health, UnitedHealthcare (UHC) Premier PPO, or the CIGNA In-Network, you are required to obtain your outpatient prescription drug benefits through your Sandia plan first. You can then file on a secondary basis with your Medicare drug plan. Class II dependents of employees who are eligible for Medicare are required to obtain their outpatient prescription drugs through their Medicare drug plan first. Sandia coverage may pay on a secondary basis.

If you are a retiree, survivor, long-term disability terminee or COBRA participant and are enrolled in the UHC Senior Premier PPO, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. You may file any non-covered expenses with the UHC Senior Premier PPO for coverage on a secondary basis.

If you are an active employee and enroll in the Kaiser Permanente Traditional HMO, you are required to obtain your prescription drugs through your Sandia coverage first. You can file on a secondary basis with your Medicare drug plan.

> **Important:** You can only waive prescription drug coverage **by waiving the entire medical plan coverage** for yourself and your dependents. Remember, if you do waive your coverage, you can only re-enroll in the medical plan coverage during the next Open Enrollment Period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should know that if you drop or lose your coverage with Sandia National Laboratories and don't enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in a Medicare drug plan later.

If you go 63 days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the Sandia Health, Benefits, and Employee Services Customer Service Center at 505-844-HBES (4237) or 1-800-417-2634, then 844-HBES for further information. **NOTE:** You will receive this notice annually. You will also get it before the next period you can enroll in the Medicare drug plan, and if this coverage through Sandia National Laboratories changes. You may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) on the web at www.socialsecurity.gov, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 30, 2009
Name of Entity/Sender: Sandia National Laboratories
Contact – Position/Office: Benefits Department
Address: 1515 Eubank S.E., Albuquerque, NM 87123
Phone Number: 505-844-HBES (4237)

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CONTACT LIST

Resource	Phone	Web Address
Sandia 800 Numbers	NM (800) 417-2634 CA (800) 472-6342	Retirees can hit "0" to get connected to the DOE locator or enter the 7 digit telephone number for the person you are calling
SNL Health Benefits & Employee Services Customer Service: Retiree Resources Summary Plan Descriptions and Forms:	 (505) 844-HBES (4237) or (800) 417-2634, ext. 844-4237	 http://hbe.sandia.gov http://www.sandia.gov
UnitedHealthcare Sandia Group #708576 Customer Service: UHC Optum NurseLine: Transplant Resources: Cancer Resources: OptumHealth Behavioral Solutions: UnitedHealth Allies:	 (877) 835-9855 (800) 563-0416 (866) 936-7246 (866) 936-6002 (866) 828-6049 (800) 860-8773	http://www.myuhc.com (use SNL for login/password) http://www.liveandworkwell.com http://unitedhealthallies.com
Catalyst Rx Customer Service: Specialty Drug Program Customer Service: Walgreens	 (866) 854-8851 (866) 823-2712	 http://www.catalystrx.com (use SNL for login/password)
CIGNA Sandia Group #3172368 Customer Service and Nurse Advice Health Information Line: Healthy Rewards:	 (800) 244-6224 (800) 870-3470	 http://www.cigna.com http://www.cigna.com/healthyrewards

Resource	Phone	Web Address
Delta Dental of Michigan Group #9550 Customer Service: Claims Lookup Access Claims Processing Address P.O. Box 9085 Farmington Hills, MI 48333-9085	(800) 264-2818	http://www.deltadental.com http://www.toolkitsonline.com
Lovelace Senior Plan (NM) Customer Service:	(505) 232-1883 or (800) 808-7363 (outside ABQ)	www.lovelacehealthplan.com
Presbyterian MediCare PPO (NM) Customer Service:	(505) 923-6060 (800) 797-5343 (outside ABQ)	www.phs.org
Kaiser (CA) Sandia Group #7455 Customer Service: Healthyroads Discount Plan: American Specialty Health Network:	(800) 464-4000 (877) 330-2746 (800) 678-9133	http://www.kp.org http://www.healthyroads.com http://ashcompanies.com
Surviving Spouse and COBRA Health Plans Customer Service UnitedHealthcare Business Services	(866) 747-0048 Business Hours: 8:00am to 8:00pm Eastern Time	www.uhcservices.com
Other Benefit Contacts Death Cases and Surviving Spouse Assistance Fidelity Investments Retiree Address Changes Prudential Pension Plan Questions	(505) 284-8327 (800) 240-4015 (505) 845-9705 (800) 421-1056	www.401K.com

PRE-MEDICARE HEALTH ASSESSMENT AND BIOMETRIC SCREENING

For the Sandia Total Health with Health Reimbursement Account (HRA) Only

Completion of the Biometric screening by your Primary Care Physician (PCP), and completion of the electronic Health Assessment, provides the primary member the maximum dollar contribution to the Health Reimbursement Account (HRA) administered by UnitedHealthcare (UHC). Pre-Medicare spouses and dependents are encouraged to complete the screening, but the screening is not required to receive the Pre-Medicare dependent(s) HRA contribution.

Step 1 - Biometric Screening (submit by March 31, 2010)

Biometric screening can be accomplished during your annual primary care physical exam.

- **Set up an annual physical with your Primary Care Physician (PCP) and have the physician complete the information below.**

Primary Member Name: **Date:**

Primary Member Social Security Number:

Biometric Measure	Result	Biometric Measure	Result
Fasting Glucose		Triglyceride	
Abdominal Circumference		Total Cholesterol	
Blood Pressure		LDL	
Weight		HDL	
Height			

Physician Signature: Date:

Fax or mail the completed form by March 31, 2010:
Attn: Biometric Screening Results
Fax: (505) 844-4091
Or
Mail to: Sandia HBE/Preventive Health
Attn: Biometric Screening Results
P. O. Box 5800 Mail Stop 1032
Albuquerque, NM 87185-1032

Step 2 - Health Assessment (submit electronically by March 31, 2010)

The Health Assessment tool is only available electronically through http://myuhc.com. UHC utilizes the University of Michigan Health Management Health Assessment tool.

Current UHC members can access the tool at anytime. New UHC members will have access to the tool on or after January 1, 2010 (once Sandia eligibility information is electronically transmitted to UHC).

- Register an account
- Navigate to Health & Wellness home page
- Select Health Assessment
- Complete the University of Michigan Health Assessment

The Biometric Screening and Health Assessment process is complete.

Your UnitedHealthcare Health Reimbursement Account will be funded with an additional $250 within 30 days of your data submission.

USE OR DISCLOSURE OF HEALTH INFORMATION:

Except as required by law, HBE will not release patient's health information without valid written authorization. HBE may review and share the patient's health information to carry out appropriate treatment or health care operations.

Follow the instructions below to make changes to your 2010 medical coverage.

STEP 1: Are you making any changes to your medical coverage for next year?

■ No	No action is necessary. DO NOT RETURN THIS FORM.
■ Yes	Continue to Step 2

STEP 2: Do you need or want to change your medical plan for next year?

Note: The Sandia Total Health is a new Pre-Medicare medical plan. All family members must be Pre-Medicare for all of 2010 except for combo Pre-Medicare and Medicare families residing in New Mexico within the Presbyterian MediCare PPO service area.

■ No	
■ Yes	

PRE-MEDICARE Member Plans		MEDICARE Member Plans	
■	**UHC Premier PPO**	■	**UHC Senior Premier PPO**
■	**Sandia Total Health**	■	**Presbyterian MediCare PPO** Must be Medicare Part A & B eligible in January 2010 and complete the Medicare Advantage Enrollment Form to enroll in this plan.
■	**CIGNA In-Network**	■	**Lovelace Senior Plan** Must be Medicare Part A & B eligible in January 2010 and complete the Medicare Advantage Enrollment Form to enroll in this plan.
■	**Kaiser Permanente Traditional HMO**	■	**Kaiser Permanente Senior Advantage** Must be Medicare Part A & B eligible in January 2010 and complete the Medicare Advantage Enrollment Form to enroll in this plan.
■	**Dental**	■	**Dental**

STEP 3: Do you want to add or drop dependents for medical or dental for next year?

■ No	Continue to Step 4.
■ Yes	Use the table below to add or drop your dependents

Add/ Drop	Name	Relationship	Birth Date/ Age	Medical	Dental

STEP 4: Please print your name and phone number below

Name (print):	Age:
Phone Number:	Social Security Number:

STEP 5: Sign & mail form in the envelope provided postmarked by November 10, 2009.

Signature:	Date:

NEW MEXICO LOVLACE SENIOR PLAN AND PRESBYTERIAN MEDICARE PPO ENROLLMENT

1) Complete the Open Enrollment Change Form 2010 (previous page)

2) Complete the Sandia Group Medicare Advantage Plan Enrollment Form (next page)
IMPORTANT: Each Medicare-primary family member must complete a Sandia Group Medicare Advantage Plan Enrollment form. **Please copy the form if you need an additional form.**

3) Mail the Open Enrollment Change Form 2010 and the Sandia Group Medicare Advantage Plan Enrollment Form(s) in the envelope included in this packet. If your packet does not have the envelope mail the forms to:

    Sandia National Laboratories
    Attn: Open Enrollment 2010, MS 1463
    P.O. Box 5800
    Albuquerque, NM 87185-1463

To Enroll, Please Provide the Following Information:

Senior Advantage Health Plan Choices (Choose One):

Lovelace Senior Plan ■ Presbyterian MediCare PPO ■

Name of Employer: Sandia National Laboratories Enrollment Effective Date: 1/1/2010

Last Name: First Name: Middle Initial

Date of Birth: Gender: ■ M ■ F

Home Phone: Cell: E-Mail Address:

Permanent Residence Address:

City: State:

Zip Code: County:

Mailing Address (only if different from your Permanent Residence Address):

City: State:

Zip Code: County:

Emergency Contact: Phone Number:

Relationship to You: E-mail address:

Please Provide Your Medicare Insurance Information

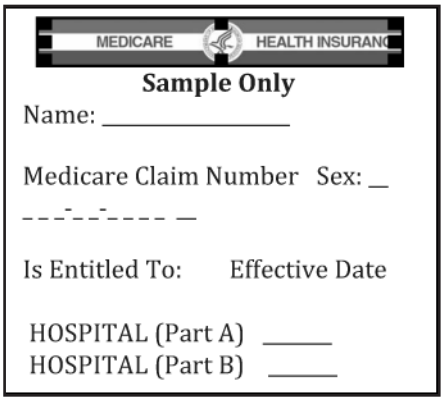
Please take out your Medicare Card to complete this section:

- Please fill in these blanks so they match your red, white and blue Medicare card

  -OR-

- Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage Plan.



Please read and answer these important questions:

1. Are you the retiree? ■ Yes ■ No If yes, retirement date (month/date/year):
   If no, Name of retiree:

2. Are you a surviving spouse? ■ Yes ■ No If yes, Name of spouse:

3. Are you covering a spouse or dependent(s) under this employer or union plan?
   ■ Yes ■ No If "yes", name of spouse:
   Name of dependent(s):

4. A.) Do you have End Stage Renal Disease (ESRD)? ■ Yes ■ No
   If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.
   B.) Diagnosis Date (MM/DD/YYYY) _____/_____/_____
   C.) Transplant Date (MM/DD/YYYY) _____/_____/_____

5. Some individuals may have other drug coverage, including other private insurance, TRI-CARE, Federal employee health benefits coverage, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the selected Senior Advantage Health Plan? ■ Yes ■ No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: ID# for this coverage: Group # for this coverage:

6. Do you or your spouse work? ■ Yes ■ No If "yes", provide the following information:
Employer Name: Employer Address:

Policy Holder Name: Policy Number:

7. Are you a resident in a long-term care facility, such as a nursing home? ■ Yes ■ No
   Date of Admission (MM/DD/YYYY) _____/_____/_____
   If "yes" please provide the following information:
   Name of Institution:
   Address & Phone Number of Institution (number and street):

8. Are you enrolled in your state-subsidized medical plan? ■ Yes ■ No
Please provide your Medicaid number:

9. If you are enrolling in the **Lovelace Senior Plan** please choose the name of a primary Care Physician (PCP):

■ New

■ Established

Por Favor verifique la siguiente caja si usted prefiere que nosotros les enviemos la información en espanol: ■

If you need information in another format or language than what is listed above and have selected:

Presbyterian MediCare PPO please call (505)923-6060 or 1-800-797-5343, Monday through Sunday from 8 a.m. to 8 p.m. TTY users should call 1-888-625-8818.

Lovelace Senior Plan please call (505) 727-5400 or 1-800-808-7363 TTY 711

If you currently have health coverage from an employer or union, joining your selected Advantage Plan could affect your employer or union health benefits. If you have health coverage from an employer or union, joining an Advantage Plan may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers about your coverage can help.

Please Read and Sign Below:
By completing this enrollment application, I agree to the following:

1. I will read the selected (Lovelace Senior Plan or Presbyterian MediCare PPO) *Member Handbook/Evidence of Coverage* when I receive it to know which rules I must follow in order to receive coverage in this Medicare Advantage plan.

2. I understand that the plan I have selected is a Medicare Advantage plan and I must maintain my enrollment in Medicare Part A and Part B insurance.

3. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in a Medicare Advantage plan, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.

4. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future.

5. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

6. I understand that I must enroll in the service area for which I reside in accordance to the Medicare Advantage Plan I have selected. Further, I understand that it is my obligation to notify the plan if I move or leave the service area so I can disenroll and find a new plan in my area.
   a. Presbyterian MediCare PPO serves a specific service area.

   b. Notify The Lovelace Senior Plan if you move outside the State of New Mexico

7. Enrollment in the selected plan is generally for the entire year.

8. I may leave this plan only at certain times of the year, or under certain special circumstances by sending a request to the selected Advantage Plan or by calling **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week.

9. I understand that starting on the effective date of my coverage, I must receive all of my medical care from my selected Medicare Advantage Plan, except for emergency care, out-of area urgent care, dialysis care while temporarily outside the service area, or authorized referrals. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage near the U.S. border (for example in Canada and Mexico). Services authorized by Lovelace Senior Plan or Presbyterian Medicare PPO, and other services contained in my Member Handbook/Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR SELECTED ADVANTAGE PLAN WILL PAY FOR THE SERVICES.

   Note: Lovelace Senior Plan and Presbyterian MediCare PPO cover emergency and urgent care worldwide.

10. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Presbyterian MediCare PPO, he/she may be compensated based on my enrollment in Presbyterian MediCare PPO.

11. Once I become a member of the selected plan, I have the right to appeal plan decisions about payment or services.

Release Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge the selected plan will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by your selected Medicare Advantage Plan or by Medicare.

Your Signature: **Today's Date:**

If you are the authorized representative , you must provide the following information:

Name:

Address:

Phone Number:

Relationship to Enrollee:

IMPORTANT: You must mail this form with the Open Enrollment Change Form 2010 postmarked by November 10, 2009.

INTERNAL USE ONLY

■ **Move SEP** ■ **LIS SEP** ■ **Institutionalized SEP** ■ **EGHP SEP**

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CALIFORNIA KAISER PERMANENTE SENIOR ADVANTAGE PLAN

1) Complete the Open Enrollment Change Form 2010

2) Complete the Kaiser Medicare Advantage Universal Enrollment/Election Form for California Group Plan

3) **IMPORTANT**: Each Medicare-primary family member must complete the Kaiser Medicare Advantage Universal Enrollment/Election Form for California Group Plan. **Please copy the form if you need an additional form.**

4) Mail the Open Enrollment Change Form 2010 and the Kaiser Medicare Advantage Universal Enrollment/Election Form for California Group Plan form(s) in the envelope included in this packet. If your packet does not have the envelope mail the forms to:

   Sandia National Laboratories
   Attn: Open Enrollment 2010, MS1463
   P. O. Box 5800
   Albuquerque, NM 87185

Sandia National Laboratories

Medicare Advantage Universal Enrollment/Election Form
California Group Plan

Medicare Advantage Plan you are requesting enrollment in:

Group Name (required)	Group #	Requested Effective Date
Desired Contracting Medical Group (if applicable)	Desired Contracting Physician (if applicable)	Medical Group/Physician No. (if applicable)

Last Name	First Name	MI	Sex ☐M ☐F

Permanent Residence Address (Street Address Only—No P.O. Box)

City State ZIP County

Mailing Address if Different (Street, City, State, ZIP)

Daytime Phone Number (including area code)	E-mail address (optional)
Evening Phone Number (including area code)	
Social Security Number (SSN)	Date of Birth

Are you the Subscriber? ☐Yes ☐No
If no, provide Subscriber Name and Social Security Number (your group may require this information)

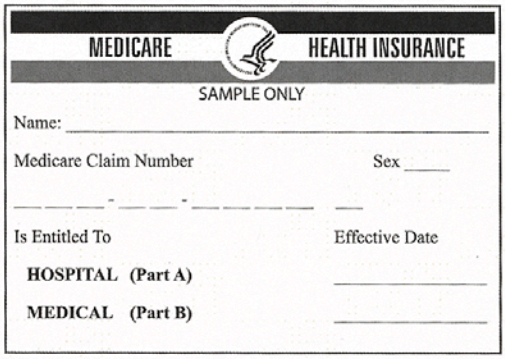
Subscriber Name _____ Subscriber SSN ___-___-____

MEDICARE HEALTH INSURANCE CARD INFORMATION

Please complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Please copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from Social Security or Railroad Retirement Board) that provides the same information.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.


MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name: _____
Medicare Claim Number Sex ____
___-___-____ ___
Is Entitled To Effective Date
HOSPITAL (Part A) _____
MEDICAL (Part B) _____

1. Are you currently a member of a Medicare Health Plan and/or Prescription Drug Plan? If so, which one? **(Your response to this question is optional.)**

   ☐Yes ☐No Plan Name _____

2. Do you have end-stage renal disease (ESRD)? ESRD is permanent kidney failure and requires you to have regular dialysis or a transplant to stay alive. If yes, enter your date of diagnosis. (required)

   ☐Yes ☐No Diagnosis Date (MM/DD/YYYY) ___/___/____

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3. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.
   Will you have other prescription drug coverage? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification (ID) number(s) for this coverage.
   Other coverage: _____ ID# _____

4. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, please provide the following information:
   Institution Name _____
   Institution Address _____
   Institution Phone Number ( ) _____ Date of Admission (MM/DD/YYYY) ___ /___ /____

5. Are you enrolled in Medi-Cal (state-subsidized medical plan)? ☐ Yes ☐ No
   If yes, please provide your Medi-Cal number: Medi-Cal# _____

6. Do you or your spouse work? ☐ Yes ☐ No

Please contact the health plan if you would prefer to receive information in a language other than English or in another format.

ARBITRATION AGREEMENT: I understand and agree that any and all disputes or disagreements (except for small claims court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) between myself, my heirs, relatives, or other associated parties, and my Medicare Advantage Organization must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings or court trial. Both the plan and the member are bound by the arbitration agreement, and the plan equally waives its right to a jury trial. This includes any and all disputes relating to or arising out of my membership with the Medicare Advantage Organization, including disputes over the denial of services, payment requests, benefits, or any cause of action or theory of liability recognized by state law. This also includes claims of medical or hospital malpractice and premises liability claims that relate to or arise from a member's relationship with the hospitals, physicians, and other providers from whom members receive or seek health care services. I understand and agree to waive my constitutional right to a trial by jury or by a court and accept the use of binding arbitration. I understand that this is a summary of the arbitration provision and that full provision is contained in the *Evidence of Coverage* and I can request a copy from my group to review prior to enrollment.

RELEASE OF INFORMATION: By joining this Medicare Health Plan, I acknowledge that the Medicare Health Plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this Medicare Health Plan will release my information, including any prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment/election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Please also read the* Conditions of Enrollment/Election *on the next page. Then sign and date below.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by this Medicare Health Plan or by Medicare.

Applicant Signature _____ Date _____
OR
Signature of authorized representative by law _____ Date _____

Authorized representative name _____ Relationship _____
(please print)
Address _____ Phone _____
Signature of any person who
assisted in completing this form _____ Date _____

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CONDITIONS OF ENROLLMENT/ELECTION

By completing this enrollment/election form, I agree to the following:

1. I will read the *Evidence of Coverage (EOC)* to know which rules I must follow in order to receive coverage in this Medicare Advantage Plan. If I don't receive a copy of the *EOC*, I may call the Medicare Advantage Plan.
2. I understand that this Medicare health plan is a Medicare Advantage Plan and has a contract with the federal government.
3. I must maintain my enrollment in Medicare Part A and Part B.
4. I can be enrolled in only one Medicare Advantage Plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in this Medicare Advantage Plan, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. If I currently have coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage Plan as I can be enrolled in only one Medicare Advantage Plan at a time. My other employer or trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employer's or trust fund's plan to select my Medicare Advantage Plan.
6. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
8. I understand that I must enroll in this Medicare Advantage Plan's service area in which I reside. Further, I understand that it is my obligation to notify the Medicare Advantage Plan if I permanently move or leave the service area for more than 6 months in a row.
9. I understand that I may leave this plan at any time by sending a written request for disenrollment to the health plan, or by calling **1-800-MEDICARE** (**1-800-633-4227**) (TTY users should call **1-877-486-2048**), 24 hours a day, 7 days a week. However, before you request disenrollment, please check with your group to determine if you are able to continue your group membership.
10. I understand that I will be notified by mail of the final confirmation of my enrollment in the plan and the effective date of my coverage. I understand that I should not disenroll from any supplemental plan until my enrollment is confirmed.
11. I understand that starting on the effective date of my coverage, I must receive all my covered health care from this Medicare Advantage Plan, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-plan providers, neither this Medicare Advantage Plan nor Medicare will be responsible for the costs. I will refer to this Medicare Advantage Plan's *EOC* for more information about covered benefits and services.
12. Once I become a member of this Medicare Advantage Plan, I have the right to appeal plan decisions about payment or services.
13. I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with this Medicare Advantage Plan, he/she may be compensated based on my enrollment in this Medicare Advantage Plan.
14. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options and concerning medical assistance through the state Medicaid program and the Medicare Savings Program.

Please read carefully before you sign this form

Benefits Choices 2010

OPEN ENROLLMENT

Health Benefits Employee Services

HBE

Your Health. Take Charge.

Sandia National Laboratories